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8  
9 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. *2013-841*

12 **DEMPNA CARAULIA DAROY, AKA**  
13 **DEMPNA SALAZAR CARAULIA**  
5141 Mendip Street  
Oceanside, CA 92057

**A C C U S A T I O N**

14 **Registered Nurse License No. 467659**

15 Respondent.  
16

17  
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of  
22 Consumer Affairs.

23 2. On or about August 31, 1991, the Board of Registered Nursing issued Registered  
24 Nurse License Number 467659 to Dempna Caraulia Daroy, aka Dempna Salazar Caraulia  
25 (Respondent). The Registered Nurse License was in full force and effect at all times relevant to  
26 the charges brought herein and will expire on June 30, 2013, unless renewed.  
27  
28

## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

## STATUTORY AND REGULATORY PROVISIONS

6. Section 2725 of the Code states, in part:

...

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

...

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

....

7. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

1 (1) Incompetence, or gross negligence in carrying out usual certified or  
2 licensed nursing functions.

3 ...

4 (d) Violating or attempting to violate, directly or indirectly, or assisting  
5 in or abetting the violating of, or conspiring to violate any provision or term of  
6 this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

7 ....

8 8. Title 16, California Code of Regulations, section 1443, states:

9 As used in Section 2761 of the code, 'incompetence' means the lack of  
10 possession of or the failure to exercise that degree of learning, skill, care and  
11 experience ordinarily possessed and exercised by a competent registered nurse  
12 as described in Section 1443.5.

13 9. Title 16, California Code of Regulations, section 1443.5, states:

14 A registered nurse shall be considered to be competent when he/she  
15 consistently demonstrates the ability to transfer scientific knowledge from  
16 social, biological and physical sciences in applying the nursing process, as  
17 follows:

18 (1) Formulates a nursing diagnosis through observation of the client's  
19 physical condition and behavior, and through interpretation of information  
20 obtained from the client and others, including the health team.

21 (2) Formulates a care plan, in collaboration with the client, which  
22 ensures that direct and indirect nursing care services provide for the client's  
23 safety, comfort, hygiene, and protection, and for disease prevention and  
24 restorative measures.

25 (3) Performs skills essential to the kind of nursing action to be taken,  
26 explains the health treatment to the client and family and teaches the client and  
27 family how to care for the client's health needs.

28 (4) Delegates tasks to subordinates based on the legal scopes of practice  
of the subordinates and on the preparation and capability needed in the tasks to  
be delegated, and effectively supervises nursing care being given by  
subordinates.

(5) Evaluates the effectiveness of the care plan through observation of  
the client's physical condition and behavior, signs and symptoms of illness, and  
reactions to treatment and through communication with the client and health  
team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating  
action to improve health care or to change decisions or activities which are  
against the interests or wishes of the client, and by giving the client the  
opportunity to make informed decisions about health care before it is provided.

## **COST RECOVERY**

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

## **FACTS**

11. At all times relevant to this Accusation, Respondent was a Registered Nurse and Nursing Supervisor during the night shift at Vista Health Care Center (hereafter "VHCC"). On September 5, 2009, Patient, a 68-year old female, was admitted to VHCC. Respondent was the admitting nurse and performed the initial nursing assessment. During this assessment, Respondent failed to notice and document that Patient had a head wound. Respondent discovered the head wound on September 19, 2009. Respondent falsified Patient's records to cover up her mistake and asked other nurses to sign off on a Treatment Administration Plan showing daily monitoring of the wound beginning on September 5, 2009.

12. On September 22, 2009, Registered Nurses A. and M. advised the Interim Director of Nursing, L.S., that Patient had a large open area on her head that had been discovered on September 19, 2009. Nurses A. and M. had not been aware of the wound until September 21, 2009. Nurses A. and M. expressed concern because the wound appeared old and infected. The wound was described as having rolled edges, slough at the center and a purulent discharge. L.S. learned that another nurse, J.T., was asked by Respondent, who was J.T.'s supervisor, to sign a Treatment Administration Record (hereinafter "TAR") for Patient that described the wound and to backdate the TAR to September 5, 2009, the date Patient was admitted. A. and M. stated the TAR was not in the chart before September 21, 2009. The TAR showed the initials of about four nurses, including Respondent, who purportedly monitored the scabbed area for infection during their shifts from September 5, 2009 to September 19, 2009.

1           13. L.S. conducted an investigation and filed a complaint with the Board. L.S. reviewed  
2 the admission assessment completed by Respondent for Patient on September 5, 2009. L.S.  
3 noticed that two colors of ink pen were used to complete the assessment form: one was a gel pen  
4 and the other a ball point pen. The only mention of a head wound were the words "scabbed area"  
5 with a line pointing to the right side of the head on an anatomical diagram. There was no  
6 narrative regarding the scabbed area in the admission assessment. There were no treatment orders  
7 on the admission order sheet.

8           14. Daily Nursing Notes for Patient from September 5, 2009 through Patient's discharge  
9 from VHCC on September 25, 2009 show that the first mention of the scabbed area was on  
10 September 19, 2009. The relevant portion of that entry stated: "Noted resident picking scabbed  
11 area on top of head, no fever (parietal area), looks infected, please follow [with] MD in AM."  
12 The notation appears to have been written by Respondent.

13           15. Nursing Notes for Patient dated September 19, 2009 at 1 p.m. stated: "[no] drainage  
14 noted from scabbed area, denies pain & discomfort. In no acute distress @ this time. Will cont. to  
15 monitor." This notation was written by another nurse.

16           16. The first treatment plan was dated September 19, 2009 and described the scabbed  
17 area as "scabbed area n parietal part of the head, 2 cm x 1.5 cm, post craniotomy site, with  
18 redness on surrounding area. No drainage. No foul odor." Respondent admitted that she  
19 prepared the treatment plan dated September 19, 2009. The treatment plan included:

20           Remind res not to pick on that affected part  
21           Keep area clean & dry  
22           Monitor for fever & report to MD....

23           17. Nursing Notes dated September 21, 2009 at 1530 hours stated:

24           Spoke to res husband regarding wound on head when res had craniotomy  
25           in 12/08. Res husband informed me of res hx to procedure & current status  
26           regarding wound. Res has been scratching area. On admission res was noted  
27           (with) scab to area. Res has been on chemotherapy for cancer & may possibly  
28           be the reason she is feeling itchy and scratching...phoned & l/m with Dr.  
             Seddiequez office to ask if they have any suggestions or any contraindicated tx's  
             for topical tx's to res wound on head."

             This entry was initialed by "AWCB." On the same date, Nurse A. completed a Request for a  
             Physician's Order to Dr. P. at 1645 hours documenting the open wound observed, Patient's

1 chemotherapy treatments and discussion with "Judy" at Dr. Seddiquez' office. This was the first  
2 request for physician's orders in the records.

3 18. During an interview with the Board's investigator, J.M., a Registered Nurse at  
4 VHCC, stated that one of the nursing staff discovered a scab on the head of a patient that was not  
5 documented on the admission assessment. The admission assessment was Respondent's  
6 responsibility as the Nursing Supervisor for the night shift. J.M. could not remember the date but  
7 recalled that Respondent approached her and other nurses who were at the nursing station at that  
8 time and asked if anyone had noticed a scab on Patient's head. J.M. and others stated that they  
9 had and Respondent asked them to make monitoring entries into the treatment record. Other  
10 nurses made the entry but J.M. did not.

11 19. S.S. was one of the nurses approached by Respondent at the nursing station. S.S.  
12 stated that in September, 2009, Respondent, her supervisor, added the treatment/monitoring of a  
13 scab to admission orders. Respondent asked her to sign off on the Treatment Administration  
14 Sheet. S.S. signed off on the TAR since she recalled having seen a scab with no signs or  
15 symptoms of infection and Patient's family had indicated it had been there since admission.

16 20. J.T., a Licensed Vocational Nurse at VHCC stated that Respondent failed to notice  
17 the scab or wound on Patient's head during her admission assessment until Patient's hair began to  
18 fall off from chemotherapy treatment. J.T. was one of the nurses approached by Respondent at  
19 the nursing station. J.T. agreed to make monitoring entries into the treatment record based on her  
20 observations. J.T. asked Respondent why Respondent did not make a new entry reporting her  
21 omission rather than backdating into the original record but Respondent chose to backdate the  
22 entries.

23 21. The policies and procedures in effect at VHCC with regard to admissions, in general,  
24 stated in part:

25 ...

26 8. Resident admitted to the facility shall be assessed initially and  
27 continuously for specific needs to determine if such needs can be met &  
28 addressed by facility.

...

16. Resident, upon admission, shall be assessed by licensed personnel of general skilled nursing needs. (Please see related policy on Nursing Admission Assessment.)

22. The policies and procedures in effect at VHCC with regard to "Admissions Orders" stated in part:

...

4. Licensed admitting nurse shall also verify with attending physician all other medications and treatment plans necessary for the care of the resident.

...

6. All admission orders verified by attending physicians should be transcribed on the physician order sheet, medication administration record (MAR) and treatment administration record (if applicable).

23. The policies and procedures in effect at VHCC with regard to "Admission Notes" stated in part:

#### **POLICY**

Specific data shall be recorded upon a resident's admission to the facility.

#### **PROCEDURE**

1. When a resident is admitted to the nursing unit [sic], the Charge Nurse must record the following data (as each may apply) in the nurses' notes or other appropriate place, as designated by nursing policy:

...

n. "Body audit" (i.e. birth marks, "ostomy" site, site and size of scars, rashes, bruises, pressure signs, lesions, decubitus, burns, general cleanliness of the body, hair, nails, etc.);

....

24. The policies and procedures in effect at VHCC with regard "Nursing Admission Assessment" stated in part:

#### **PROCEDURE**

1. On admission, licensed charge nurse shall be responsible for initial data collection and assessment of resident's immediate and long-term nursing needs.

2. Licensed charge nurse shall conduct a "head to toe" assessment of the resident, noting skin condition for hygiene, skin turgor, scars, etc.

3. Data collection and assessment shall include:

a. Assessment of skin condition, including body marks or recent scars, bruises, skin discolorations, abrasions, pressure ulcers or any questionable markings (include size, depth in centimeters, color and drainage, if any ) or edema

...

4. The nursing admission data collection and assessment form shall be used in documenting information vital to a resident's physical, functional, sensory, nutritional and psychosocial conditions. Document other findings (not indicated in the form) in the licensed nurse progress notes.

....

25. The policies and procedures in effect at VHCC with regard to "Documentation – Charting Errors and/or Omissions stated in part:

**Policy:** All resident records will be maintained with the original documentation intact.

**Procedures:**

...

2. Late entries in the medical record shall be date at the time of the entry and noted as a "late entry." Late entries shall be completed within the next working day.

...

4. At no time will any documentation be recopied or otherwise changed except as directed in this policy.

...

6. All correction, changes or addenda must be signed and dated by the person making such entries.

....

### **FIRST CAUSE FOR DISCIPLINE**

#### **(Incompetence-Failure to Observe, Assess and Formulate Care Plan)**

26. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for incompetence, as defined by title 16, California Code of Regulations, sections 1443 and 1443.5, in that Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse in her care of

1 Patient. Respondent failed to observe and assess Patient's head wound upon Patient's admission  
2 to VHCC and consequently failed to formulate a care plan until weeks after Patient's admission,  
3 as more fully set forth in paragraphs 11 – 25 above, and incorporated by this reference as though  
4 set forth in full herein.

## 5 **SECOND CAUSE FOR DISCIPLINE**

### 6 **(Incompetence-Falsify Entries in Patient Records)**

7 27. Respondent is subject to disciplinary action under Code section 2761, subdivision  
8 (a)(1), for incompetence, as defined by title 16, California Code of Regulations, sections 1443  
9 and 1443.5, in that Respondent failed to exercise that degree of learning, skill, care and  
10 experience ordinarily possessed and exercised by a competent registered nurse in that Respondent  
11 falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in Patient's  
12 records by backdating entries in Patient's records pertaining to a head wound, as more fully set  
13 forth in paragraphs 11 – 25 above, and incorporated by this reference as though set forth in full  
14 herein.

## 15 **THIRD CAUSE FOR DISCIPLINE**

### 16 **(Aiding and Abetting Violation of Nursing Practice Act)**

17 28. Respondent is subject to disciplinary action under Code section 2761, subdivision (d),  
18 in conjunction with Code section 2761, subdivision (a)(1), for unprofessional conduct in that  
19 Respondent aided or abetted the violation of, or conspired to violate, the Nursing Practice Act.  
20 Respondent asked the nurses over whom Respondent had supervisory control to backdate entries  
21 in Patient's records to show that Patient's head wound was assessed and monitored daily from the  
22 time of Patient's admission to VHCC on September 5, 2009 when in fact the wound had not been  
23 discovered before September 19, 2009, as more fully set forth in paragraphs 11 – 25 above, and  
24 incorporated by this reference as though set forth in full herein.

## 25 **FOURTH CAUSE FOR DISCIPLINE**

### 26 **(Unprofessional Conduct)**

27 29. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)  
28 for unprofessional conduct in that Respondent failed to observe and assess Patient's head wound


1 upon admission and backdated, or cause to be backdated, entries in Patient's records pertaining to  
2 a head wound, in violation of VHCC's policies and procedures, as more fully set forth in  
3 paragraphs 11 – 25 above, and incorporated by this reference as though set forth in full herein.

4 **PRAYER**

5 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
6 and that following the hearing, the Board of Registered Nursing issue a decision:

- 7 1. Revoking or suspending Registered Nurse License Number 467659, issued to  
8 Dempna Caraulia Daroy, aka Dempna Salazar Caraulia;  
9 2. Ordering Dempna Caraulia Daroy, aka Dempna Salazar Caraulia, to pay the Board of  
10 Registered Nursing the reasonable costs of the investigation and enforcement of this case,  
11 pursuant to Business and Professions Code section 125.3; and,  
12 3. Taking such other and further action as deemed necessary and proper.

13  
14  
15 DATED: March 27, 2013

16 *for*   
17 LOUISE R. BAILEY, M.ED., RN  
18 Executive Officer  
19 Board of Registered Nursing  
20 Department of Consumer Affairs  
21 State of California  
22 Complainant

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